# PATIENT HISTORY FORM

(Please Print)

Your Name: (Last)_____ (First) _____ (M.I.) _____

Date of Birth: ____/_____/_____ Family Doctor: _____

**Don't worry if you have any questions about how to fill out this form! Just ask our staff or your provider to help clarify any information.**

## PAST MEDICAL HISTORY

**(If YOU have EVER had any of these conditions, please indicate with an X or √ )**

### Breast Conditions

____ Abnormal Mammogram (fill in below)
date:_____ result: _____
____ Breast Cancer ☐ Left ☐ Right
____ Breast Implants
____ Fibrocystic Breasts
____ Other _____

### Gyn Problems

____ Abnormal Pap Smear (fill in below)
date:_____ circle treatment: colpo/LEEP/cryo
____ Cervical Cancer or "Precancer"
____ Dysmenorrhea (Painful Menses)
____ Endometrial (Uterine) Cancer
____ Endometriosis
____ Fibroids
____ Herpes - first outbreak? Yes/No Where:_____
____ Human Papilloma Virus Infection (HPV)
____ Ovarian Cancer
____ Ovarian Cysts
____ Pelvic Inflammatory Disease (PID)
____ Polycystic Ovarian Syndrome (PCOS)
____ Sexually Transmitted Disease (fill in below)
date: _____ type: _____
____ Vaginal Cancer
____ Vulvar Cancer
____ Other _____

### Heart or Circulation Conditions (Cardiovascular)

____ Congenital Heart Disease
____ Congestive Heart Failure
____ Coronary Artery Disease
____ CVA (Stroke)
____ Hypertension (High Blood Pressure)
____ Irregular Heart Beat
____ Mitral Valve Prolapse
____ Pulmonary Embolism (Blood Clot in Lung)
____ Thrombophlebitis (Blood Clot in Extremity)

### Endocrine (Glandular) Disorders

____ Diabetes – Type I (Insulin-dependent - youth)
____ Diabetes – Type II (Adult onset)
____ Pituitary Gland Disorder
____ Thyroid Disease: circle one: Hypo / Hyper
____ High Cholesterol

### Immune System Diseases

____ Chronic Fatigue Syndrome
____ Other _____

### Gastrointestinal (GI) Problems

____ Colitis, Ulcerative
____ Crohn's Disease
____ Hepatitis A
____ Hepatitis B
____ Hepatitis C
____ Irritable Bowel Syndrome
____ Other _____

### Blood (Hematologic) Disorders

____ Anemia
____ Bleeding Disorder
____ Clotting Disorder
____ Sickle Cell Trait or Disease/Thalassemia
____ Other _____

### Musculoskeletal Disorders

____ Arthritis, Rheumatoid
____ Arthritis, Other
____ Joint Pain
____ Fibromyalgia
____ Osteopenia ("Low bone mass")
____ Osteoporosis
____ Scoliosis
____ Systemic Lupus Erythematosis
____ Other _____

### Neurologic Disorders

____ Common Migraines
____ Headaches (Other)
____ Multiple Sclerosis
____ Seizure Disorder (Epilepsy)
____ TIA or Stroke
____ Other _____

### Skin Conditions

____ Acne (severe)
____ Eczema
____ Hirsutism (Excess Hair Growth)
____ MRSA
____ Psoriasis
____ Other _____

Your Name: _____

**Psychiatric or Emotional Conditions**
_____ ADHD/ADD
_____ Bipolar (Manic-Depressive)
_____ Major Depression
_____ OCD (Obsessive-Compulsive)
_____ Postpartum Depression
_____ Severe Anxiety or Panic Attacks
_____ Other _____

**Respiratory (Lung) or ENT Disorders**
_____ Asthma
_____ COPD
_____ Lung Cancer
_____ Pneumonia - Recurrent
_____ Sleep Apnea

**Genetic Disorders**
____ Cystic Fibrosis
____ Muscular Dystrophy
____ Other
____ Tuberculosis
____ Other _____

**Urinary (Urological) Disorders**
____ Calculus (Kidney Stones)
____ Pyelonephritis
____ Stress Incontinence
____ Urge Incontinence/Overactive Bladder
____ Urinary Tract Infections (UTI)
____ Other _____

**Deatails and Comments**
_____
_____
_____

## PAST SURGICAL HISTORY

**(Please include any D&C, D&E, colposcopy, cryotherapy or colonoscopy surgeries)**

| Surgery | Reason | When |
|---|---|---|
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## HERBS, VITAMINS AND SUPPLEMENTS YOU ARE TAKING

| Product name | Dose (if known) | How Often | Start Date | Reason |
|---|---|---|---|---|
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| | | | | |

Your Name:_____

## MEDICATIONS YOU ARE TAKING

| Drug name | Dose | How Often | Start Date | Prescribed by |
|---|---|---|---|---|
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Primary Pharmacy Name _____ phone # _____

Pharmacy Address: _____

## ALLERGIES

Do you have any known medication allergies? YES NO (please describe allergies in chart below)

Allergic to any of the following (circle those that apply):

Contrast Dye (used in x-ray studies) Nickel Peanuts Latex Shellfish Other _____

If yes, please list all allergies here and the allergic reaction

| Allergy | What happens? |
|---|---|
| | |
| | |
| | |
| | |
| | |

Your Name: _____

## FAMILY MEDICAL HISTORY

(If **ANY** close relative of yours - such as brothers, sisters, parents, children, grandparent (maternal or paternal), or aunt or uncle - has EVER HAD or CURRENTLY HAS any of the problems listed below, please ENTER AN X in the YES column and then enter the specific relationship to you.

Endometriosis ☐ Yes ☐ No Who: Be specific_____

Breast Cancer ☐ Yes ☐ No Who: Be specific_____ Age of diagnosis: _____

Colon Cancer ☐ Yes ☐ No Who: Be specific_____

Heart Disease ☐ Yes ☐ No Who: Be specific_____

High Blood Pressure ☐ Yes ☐ No Who: Be specific_____

High Cholesterol ☐ Yes ☐ No Who: Be specific_____

Blood Clots ☐ Yes ☐ No Who: Be specific_____

Diabetes – Childhood ☐ Yes ☐ No Who: Be specific_____

Diabetes – Adult Onset ☐ Yes ☐ No Who: Be specific_____

Hypothyroidism ☐ Yes ☐ No Who: Be specific_____

Lung Cancer ☐ Yes ☐ No Who: Be specific_____

Mental Retardation ☐ Yes ☐ No Who: Be specific _____

Ovarian Cancer ☐ Yes ☐ No Who: Be specific_____ Age of diagnosis: _____

Uterine Cancer ☐ Yes ☐ No Who: Be specific_____ Age of diagnosis: _____

Other Cancer (What Kind)_____ ☐ Yes ☐ No Who: Be specific_____ _____

Osteoporosis ☐ Yes ☐ No Who: Be specific_____

## MENSTRUAL AND CONTRACEPTION HISTORY

AGE MENSTRUAL PERIODS BEGAN_____ AGE OF MENOPAUSE _____

BIRTH CONTROL METHODS EVER USED

___Never been sexually active ___Birth Control Patches ___Condoms or Diaphragm

___Birth Control Pills/Shots/Implants ___Tubaligation/Essure ___Spermicide

___Birth Control Shots (Depo-Provera) ___Vasectomy ___Natural family planning/Rhythm

___Implants (Implanon) ___IUD ___Other

CURRENT METHOD OF BIRTH CONTROL: _____

## PREGNANCY SUMMARY (how many?)

| Total Number of Pregnancies | Full Term Births (> 37 wks) | Premature Births (< 37 wks) | Terminations | Miscarriages Was Surgery Needed? | Ectopic pregnancies Left or Right? | Number of Living Children |
|---|---|---|---|---|---|---|
| | | | | | | |

Please provide date of terminations, miscarriages and ectopic pregnancies.

Comments: _____

_____

Your Name:_____

## PREGNANCY DETAILS

| Child's Birthdate M/DD/YY | Child's Name | # weeks at Delivery | Length of Labor | Birth Wt. | M or F | Type of Delivery (Vaginal or C/S) | Anesth-esia | Complications/ Problems | Physician | Location |
|---|---|---|---|---|---|---|---|---|---|---|
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## SOCIAL HISTORY

**Marital Status:** ☐ Divorced ☐ Engaged ☐ Married ☐ Separated ☐ Single ☐ Widowed

**Alcohol Use:** ☐ Never ☐ Current ☐ Former How Much: _____

____ Age started ____ Age stopped

**Street Drug Use:** ☐ Never ☐ Current ☐ Former Which Drug(s): _____

How Often: _____ ____ Age started ____ Age stopped _____ When last used

**Tobacco Use:** ☐ Never ☐ Current ☐ Former How Much: _____

____ Age started ____ Age stopped

**Exercise Habits:** ☐ Active but no formal exercise ☐ Heavy amount of exercise (4 or more times weekly)

☐ Minimal amount of exercise (Once weekly or less) ☐ Moderate amount of exercise (1-3 times weekly) ☐ Sedentary

Type of exercise: _____

**Education (how far did you go in school?):**

☐ Did not finish high school ☐ High school or GED ☐ Some college

☐ College degree ☐ Graduate or professional degree

**Occupation:** _____